Clear Form Save Form

MENTAL HEALTH SCREENING FORM

SECURE ***Form must be completed fully and electronically*** *Revised: 1/2022*

I. IDENTIFYING DATA

Screen Urgency | Tracking # | Referring Agency

Contact Person | Contact Number

Screen Date | CMHC/HIS | QMHP/LMHP

Interview Location | Start Time ☐am ☐pm | Decision Time ☐am ☐pm

If a Rescreen:
Date | QMHP | Start Time ☐am ☐pm | Decision Time ☐am ☐pm

COURTESY SCREEN ☐Yes ☐No

Requesting CMHC | Approved by

COMMUNITY PSYCHIATRIC HOSPITAL DENIALS (not state or SIA hospitals)

Other private psychiatric facilities ruled out for private placement (not SIAs): ☐Yes ☐No

Facility Denial (Name; not SIA beds) | Facility Denial (Name; not SIA beds):

CLIENT DATA

NAME: Last, First Middle

Pre-Marital Name | Also Known As (AKA)

Date of Birth | Age 0 | Race

Sex at Birth (Male/Female) | Pronouns

SSN | Veteran ☐Yes ☐No ☐Unk

Street Address | City

State | Zip | Phone #

County of Residence | County of Responsibility

CMHC Consumer Status:
- ☐ Current CMHC Consumer
- ☐ Former CMHC Consumer
- ☐ Other CMHC Consumer
- ☐ Never a CMHC Consumer
- ☐ Private Practice Consumer
- ☐ Unknown

Custody Status: ☐ None ☐DCF ☐DOC ☐ Parental ☐ Guardian

Have guardian letter/document? ☐Yes ☐No

Guardian Name | Phone #

Guardian Name | Phone#

Current OTO (Outpatient Treatment Order)?
☐ Yes ☐No ☐Unknown

Screening Informant(s):
- ☐Self
- ☐Family / Significant Other
- ☐CMHC/Private Provider
- ☐Hospital/Inpatient/Residential Staff
- ☐DCF Contact
- ☐DOC Contact
- ☐LEO (Law Enforcement Officer)
- ☐Other:

II. SUPPORT SYSTEMS

SOCIAL SUPPORTS

This individual has others involved in a helpful way (check):
☐Parent ☐Family ☐Friends ☐Case Worker ☐Neighbor ☐N/A ☐Other:

Name Phone # Relationship to Client

Name Phone # Relationship to Client

Support System: ☐Adequate ☐Limited ☐None ☐Receiving HCBS Services
Living Situation: ☐Stable ☐Independent ☐Precarious ☐Homeless ☐Currently Incarcerated

Explain:

FINANCIAL RESOURCES

Employment: ☐Employed ☐Unemployed ☐Disabled ☐Other:

Insurance: ☐Medicaid #: ☐Pending Medicaid
☐Medicare #: ☐Uninsured
☐Other Ins.:

III. PRESENTING PROBLEM(S) – CHECK ALL THAT APPLY

Harm to SELF:	☐Current Danger	☐Potential Danger	☐Self Care Failure	☐Substance Abuse
Harm to OTHERS:	☐Current Danger	☐Potential Danger	☐Suicidal/Homicidal	☐Psychotic Symptoms
Harm to PROPERTY:	☐Current Danger	☐Potential Danger	☐Mood Disorder	☐Other

Explain concerns in detail:

IV. RISK FACTORS

DANGER TO SELF, Current

☐None ☐Ideation ☐Plan ☐Threat ☐Gesture/Attempt ☐Intent w/o Means ☐Intent w/ Means
☐At Risk ☐Self Care Failure ☐Able to participate in safety planning ☐Risk aggravated by Substance Use
Explain (include dates, means, rescue):

DANGER TO SELF, History

☐None ☐Ideation ☐Plan ☐Threat ☐Gesture/Attempt ☐Intent w/o Means ☐Intent w/ Means
☐Self Care Failure ☐Risk aggravated by Substance Use ☐Unknown
Explain (include dates, means, rescue):

IV. RISK FACTORS, *continued*

DANGER TO OTHERS, Current

☐None ☐Ideation ☐Plan ☐Threat ☐Gesture/Attempt ☐Intent w/o Means ☐Intent w/ Means
☐At Risk ☐Able to participate in safety planning ☐Risk aggravated by Substance Use

Explain (include dates, means, rescue):

DANGER TO OTHERS, History

☐None ☐Ideation ☐Plan ☐Threat ☐Gesture/Attempt ☐Intent w/o Means ☐Intent w/ Means
☐Risk aggravated by Substance Use ☐Unknown

Explain (include dates, means, rescue):

DESTRUCTION OF PROPERTY

Current: ☐Yes ☐No ☐Unknown ☐N/A **History**: ☐Yes ☐No ☐Unknown ☐N/A

Explain:

KNOWS SOMEONE WHO ATTEMPTED OR DIED BY SUICIDE

☐Yes ☐No ☐Unknown

Explain (relationships, dates, relevant info):

ABUSE

☐None ☐Current ☐Past ☐Unknown

If yes, types: ☐Physical ☐Sexual ☐Emotional ☐Neglect

If yes, individual is: ☐Victim ☐Perpetrator ☐Both ☐Neither, but abuse reported in environment

Explain:

IV. RISK FACTORS, *continued*

ADDICTION

Substance Use: ☐None ☐Current ☐Past ☐Unknown **Gambling**: ☐None ☐Current ☐Past ☐Unknown
Positive BAL ☐Yes ☐No Level: **Internet:** ☐None ☐Current ☐Past ☐Unknown
Positive UDS ☐Yes ☐No Substance(s):

DRUGS OF CHOICE	Primary Drug	Secondary Drug	Tertiary Drug
Name of Drug			
Currently Using	☐Yes ☐No ☐Unknown	☐Yes ☐No ☐Unknown	☐Yes ☐No ☐Unknown
Past Use	☐Yes ☐No ☐Unknown	☐Yes ☐No ☐Unknown	☐Yes ☐No ☐Unknown
Frequency	☐Unknown ☐N/A	☐Unknown ☐N/A	☐Unknown ☐N/A
Amount	☐Unknown ☐N/A	☐Unknown ☐N/A	☐Unknown ☐N/A
Last Date of Use	☐Unknown ☐N/A	☐Unknown ☐N/A	☐Unknown ☐N/A

SUBSTANCE USE TREATMENT

☐None ☐Detox ☐Outpatient ☐Inpatient ☐Oxford House/similar ☐Unknown ☐N/A
Explain (Include current/history):

Complications related to detoxification/withdrawal (seizures, etc.): ☐N/A ☐Unk

MEDICATIONS (List all current medications. Specify Name & Dosage) ☐ Medication list is attached

Taking as directed: (Y) Yes (N) No (U) Unk		*Y*	*N*	*U*			*Y*	*N*	*U*
Medication:	Dosage: Last Dose Taken:	☐	☐	☐	Medication:	Dosage: Last Dose Taken:	☐	☐	☐
Medication:	Dosage: Last Dose Taken:	☐	☐	☐	Medication:	Dosage: Last Dose Taken:	☐	☐	☐
Medication:	Dosage: Last Dose Taken:	☐	☐	☐	Medication:	Dosage: Last Dose Taken:	☐	☐	☐

MEDICAL CONCERNS

Reported by: ☐Self ☐Family ☐Primary Care Physician ☐Medical Records

☐Drug Allergies: ☐Other Allergies: ☐None ☐Unknown

Psychiatrist Location ☐Unknown

Primary Care Physician Location ☐Unknown

IV. RISK FACTORS, *continued*

MEDICAL CONCERNS, *continued*

☐ **None of the following medical concerns have been reported**

Please put an X in the box as applicable on each line (Y) Yes (N) No (U) Unknown (N/A) Not application

	Y	N	U	N/A		Y	N	U	N/A
Patient requires O2	☐	☐	☐	☐	Patient requires other durable medical equipment. *If yes, explain below in Medical Q4*	☐	☐	☐	☐
If yes, will the patient be coming with O2?	☐	☐	☐	☐	Patient will bring this equipment if admitted?	☐	☐	☐	☐
Patient has a urinary catheter	☐	☐	☐	☐	Patient needs assistance with ADLs? *If yes, use Medical Q5*	☐	☐	☐	☐
If yes, will it be removed?	☐	☐	☐	☐	Patient needs assistance in ambulating. *If yes, provide details in Medical Q6*	☐	☐	☐	☐
IV or Central Line	☐	☐	☐	☐	Patient has a history of multi-drug resistant organism (MRSA, etc.)	☐	☐	☐	☐
If yes, will it be removed?	☐	☐	☐	☐	Patient is confined to a bed	☐	☐	☐	☐
Patient is on Dialysis. *If yes, provide details below use Medical Q1*	☐	☐	☐	☐	Patient requires 1:1 staff at their current placement	☐	☐	☐	☐
Patient requires a ventilator. *If yes, provide details below use Medical Q2*	☐	☐	☐	☐	Patient has an open wound. *If yes, provide details below in Medical Q7*	☐	☐	☐	☐
Patient requires a CPAP. *If yes, provide details below in Medical Q3*	☐	☐	☐	☐	Patient has allergies. *If yes, provide details below use Medical Q8*	☐	☐	☐	☐
If yes, patient will be coming with equipment?	☐	☐	☐	☐					

Explanations by question for the above table:

Medical Q1 Dialysis Details:

Medical Q2 Ventilator Details:

Medical Q3 CPAP Details

Medical Q4 Medical Equipment Details:

Medical Q5 ADL Barrier Details:

Medical Q6 Ambulatory Details:

Medical Q7 Open Wound Details:

Medical Q8 Allergy Details:

V. CLINICAL IMPRESSIONS

General Appearance
- ☐ Appropriate hygiene/dress
- ☐ Poor personal hygiene
- ☐ Overweight ☐ Underweight
- ☐ Eccentric ☐ Seductive

Sensory/Physical Limitations
- ☐ No limitations noted
- ☐ Hearing ☐ Visual
- ☐ Physical ☐ Speech

Mood
- ☐ Calm ☐ Euthymic
- ☐ Cheerful ☐ Anxious
- ☐ Depressed ☐ Fearful
- ☐ Suspicious ☐ Labile
- ☐ Pessimistic ☐ Irritable
- ☐ Euphoric ☐ Hostile
- ☐ Guilty ☐ Apathetic
- ☐ Dramatized ☐ Hopelessness
- ☐ Elevated ☐ Marked shifts

Affect
- ☐ Primarily appropriate
- ☐ Primarily inappropriate
- ☐ Congruent ☐ Incongruent
- ☐ Constricted ☐ Tearful
- ☐ Blunted ☐ Flat
- ☐ Detached

Speech
- ☐ Unable to assess
- ☐ Logical/Coherent ☐ Loud
- ☐ Delayed responses ☐ Tangential
- ☐ Rambling ☐ Slurred
- ☐ Rapid/Pressured
- ☐ Incoherent/Loose associations
- ☐ Soft/Mumbled/Inaudible

Thought Content/Perceptions
- ☐ Unable to assess ☐ Delusions
- ☐ No disorder noted ☐ Grandiose
- ☐ Paranoid ☐ Racing
- ☐ Bizarre ☐ Flight of ideas
- ☐ Circumstantial ☐ Obsessive
- ☐ Disorganized ☐ Blocking
- ☐ Ruminations/Intrusive thoughts
- ☐ Auditory hallucinations
- ☐ Visual hallucinations
- ☐ Other hallucinatory activity
- ☐ Ideas of reference
- ☐ Illusions/Perceptual distortions
- ☐ Depersonalization/Derealization

Memory
- ☐ Unable to assess ☐ No impairment
- ☐ Impaired immediate
- ☐ Impaired remote ☐ Impaired recent

Insight (Age Appropriate)
- ☐ Unable to assess
- ☐ Good ☐ Fair
- ☐ Poor ☐ Lacking

Orientation
- ☐ Unable to assess ☐ Oriented x 4
- ☐ Impaired: ☐ time ☐ situation ☐ place ☐ person

Cognition/Attention
- ☐ Unable to assess
- ☐ No impairment noted
- ☐ Distractibility/Poor concentration
- ☐ Impaired abstract thinking
- ☐ Impaired judgment
- ☐ Indecisiveness

Behavior/Motor Activity
- ☐ Unable to assess
- ☐ Normal/Alert ☐ Poor eye contact
- ☐ Cooperative ☐ Uncoordinated
- ☐ Catatonic ☐ Self-destructive
- ☐ Lethargic ☐ Tense
- ☐ Agitated ☐ Tremors/Tics
- ☐ Withdrawn ☐ Provocative
- ☐ Impulsiveness ☐ Aggression/Rage
- ☐ Restless/Overactive
- ☐ Repetitious ☐ Bizarre behavior
- ☐ Peculiar mannerisms
- ☐ Indiscriminate socializing
- ☐ Disorganized behavior
- ☐ Feigning of symptoms
- ☐ Avoidance behavior
- ☐ Increase in social, occupational, sexual activity
- ☐ Decrease in energy, fatigue
- ☐ Loss of interest in activities
- ☐ Compulsive (including gambling/internet)

Eating/Sleep Disturbance
- ☐ Unable to assess
- ☐ No disturbance noted
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Binge eating
- ☐ Self-induced vomiting
- ☐ Weight loss (lbs/time):
- ☐ Weight gain (lbs/time):
- ☐ Increased sleep
- ☐ Decreased sleep
- ☐ Bed-wetting
- ☐ Nightmares/Night terrors

Anxiety Symptoms
- ☐ Unable to assess
- ☐ Within normal limits
- ☐ Generalized anxiety
- ☐ Fear of social situations
- ☐ Panic attacks
- ☐ Obsessions/Compulsions
- ☐ Hyper-vigilance
- ☐ Reliving traumatic events

Conduct Disturbance
- ☐ Unable to assess
- ☐ Conduct appropriate
- ☐ Stealing ☐ Lying
- ☐ Projects blame ☐ Fire setting
- ☐ Short-tempered
- ☐ Defiant/Uncooperative
- ☐ Violent behavior
- ☐ Cruelty to animals/People
- ☐ Running away ☐ Truancy
- ☐ Criminal activity
- ☐ Vindictive
- ☐ Argumentative
- ☐ Antisocial behavior
- ☐ Destructive to others or property

Occupational & School Impairment
- ☐ Unable to assess
- ☐ No impairment noted
- ☐ Impairment grossly in excess than expected in physical finding
- ☐ Impairment in occupational functioning
- ☐ Impairment in academic functioning
- ☐ Not attending school/work

Interpersonal/Social Characteristics
- ☐ Unable to assess
- ☐ No significant trait noted
- ☐ Chooses relationships that lead to disappointment
- ☐ Expects to be exploited/harmed by others
- ☐ Indifferent to feelings of others
- ☐ Interpersonal exploitiveness
- ☐ No close friends or confidants
- ☐ Unstable and intense relationships
- ☐ Excessive devotion to work
- ☐ Inability to sustain consistent work
- ☐ Perfectionist ☐ Grandiose
- ☐ Procrastinates ☐ Entitlement
- ☐ Persistent emptiness & boredom
- ☐ Constantly seeking praise of admiration
- ☐ Excessively self-centered
- ☐ Avoids significant interpersonal contacts
- ☐ Manipulative/Charming/Cunning

NOTES:

VI. TREATMENT / PLACEMENT INFORMATION

TREATMENT HISTORY

Currently in Treatment: ☐ Yes ☐ No ☐ Unknown

Agency/Service(s): Therapist Case Manager

Service progress/failure(s):

Previously Hospitalized: ☐ Yes ☐ No ☐ Unknown ☐ State Hospital/SIA

Multiple Hospitalizations: ☐ Yes Number: ☐ No ☐ Unknown

Last psychiatric hospitalization:

Facility Date Admitted Date Discharged AMA? ☐ Yes ☐ No ☐ Unknown

PLACEMENT HISTORY

Placement/Admission History (mark all that apply)

☐ Detention ☐ Foster Care ☐ PRTF ☐ QRTP ☐ YRC ☐ Secure Care ☐ NFMH

☐ Other:

Comments:

EDUCATIONAL HISTORY

☐ Unknown

Name of School Highest Grade Completed

Educational concerns and current supports (IEP, GED, LD, etc.):

CRIMINAL / LEGAL

Charges Pending: ☐ Yes ☐ No ☐ Unknown

History in corrections system and/or as a juvenile offender: ☐ Yes ☐ No ☐ Unknown

Determined by court to be: ☐ CINC ☐ JO ☐ N/A ☐ Other

VII. INPATIENT PSYCHIATRIC HOSPITALIZATION CRITERIA

LEVEL 1, INDEPENDENT: Criteria which, in & of themselves, MAY constitute justification for admission.

- ☐ 1. Suicide attempt, threats, gestures indicating potential danger to self.
- ☐ 2. Homicidal threats or other assaultive behavior indicating potential danger to others.
- ☐ 3. Extreme acting out behavior indicating danger or potential danger to property.
- ☐ 4. Self-care failure indicating an inability to manage daily basic needs that may cause self-injury.

LEVEL 2, DEPENDENT: Clinical characteristics of psychiatric disorders, any of which in combination with at least ONE Level 3 Criteria, MAY constitute justification for admission.

- ☐ 5. Clinical depression.
- ☐ 6. Intense anxiety or panic that may cause injury to self or others.
- ☐ 7. Loss of reality testing with bizarre thought processes such as paranoia, ideas of reference, etc.
- ☐ 8. Impaired memory, orientation, judgment, incoherence or confusion.
- ☐ 9. Impaired thinking and/or affect accompanied by auditory or visual hallucinations.
- ☐ 10. Mania or hypomania.
- ☐ 11. Mutism or catatonia.
- ☐ 12. Somatoform disorders.
- ☐ 13. Severe eating disorders such as bulimia or anorexia.
- ☐ 14. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances.
- ☐ 15. Severe maladaptive or destructive behaviors in school, home or placement, which may include excessive use of substances.
- ☐ 16. Extremely impulsive and demonstrates limited ability to delay gratification.

LEVEL 3, CONTINGENT: Acute-care program needs which MAY justify psychiatric hospital admission.

- ☐ 17. Need for medication evaluation or adjustment under close medical observation.
- ☐ 18. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less intensive levels of care.
- ☐ 19. Need for continuous secure setting with skilled observation and supervision.
- ☐ 20. Need for 24-hour structured therapeutic milieu to implement treatment.

☐ **Patient does not meet criteria for inpatient psychiatric hospitalization.**

Qualified Mental Health Professional Signature Date

VIII. INVOLUNTARY HOSPITALIZATION CRITERIA

For Involuntary Admission, must meet criteria 1, 2, and 3, plus 4 and/or 5 below, per KSA statue.

Must meet:

☐ 1. Is suffering from a severe mental disorder to the extent that he/she needs involuntary care in a State Hospital. ***AND***

☐ 2. Lacks the capacity to make an informed decision concerning his/her need for treatment. ***AND***

☐ 3. Is not manifesting a primary diagnosis of antisocial personality disorder, chemical abuse/addiction, mental retardation, organic personality syndrome, or an organic mental disorder.

At least one:

☐ 4. Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior causing, attempting, or threatening such injury, abuse or damage ***OR***

☐ 5. Is substantially unable, except for a reason of indigence, to provide for any of his/her basic needs, such as food, clothing, shelter, health, or safety, causing a substantial deterioration of the person's ability to function with current level of support, care, or structure.

☐ **Patient does not meet criteria for involuntary psychiatric hospitalization.**

Please note for children under 18, admission to a SIA must be by:

1. Voluntary application for a child aged 14 or over.
2. Voluntary application by a parent.
3. Voluntary application by legal guardian or by DCF if parental rights have been severed (with appropriate court authority, see KSA 59-3018a).
4. Involuntary civil commitment.

XI. DIAGNOSTC IMPRESSIONS

Meets Criteria For: ☐SED ☐SPMI ☐Unknown ☐N/A

Code Diagnosis

Code Diagnosis

Code Diagnosis

Additional Dx or notes:

Qualified Mental Health Professional Signature Date

IX. SCREENING DISPOSITION

☐ Recommended **involuntary admission** to (State Hospital/SIA)*
in accordance with KSA Statue.

☐ Recommended **involuntary outpatient commitment** to

☐ Recommended **voluntary admission** to (State Hospital/SIA)*

☐ Not in need of inpatient psychiatric treatment.

☐ Community-based plan created in lieu of hospitalization (SEE PAGE 12), copy given to legally responsible individual.

*****Refer to http://bedcount.healthsrc.org for available voluntary or involuntary beds at State Hospitals and SIAs*.

X. REIMBURSEMENT AUTHORIZATION

☐ **(A) Meets inpatient criteria, state hospitalization recommended**: ☐ Voluntary ☐ Involuntary
Admitted / transferred to hospital Admission Date

☐ **(B) Meets inpatient criteria, but not state hospital/SIA admission.**

☐ **(C) Does not meet inpatient criteria, outpatient community services plan recommended.**

☐ Copy of community-based plan given to legally responsible individual.

I certify that local community resources have been investigated and/or consulted to determine whether any of them can furnish appropriate and necessary care. I have seen this individual and have evaluated him/her and his/her situation. I have also considered alternate modes of treatment. All community resources have been investigated and are not available if hospitalization is recommended.

XII. DISCHARGE PLAN

OTO Recommended? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Treatment expectations / Preliminary discharge plan / Community-based plan instructions given to patient

Qualified Mental Health Professional Signature Date

XIII. CLINICAL SUMMARY

NARRATIVE

XIV. TIME DOCUMENTATION SUMMARY

Contact / Activity	**Amount of Time**
Chart Review	_____
Paperwork	_____
Face-to-Face Interview	_____
Collateral Contacts / Coordination	_____
Consultation /Team Meetings	_____

Total Screen Time: _____Hours _____Minutes

Travel Time to/From: _____Hours _____Minutes

TOTAL TIME: _____Hours _____Minutes

RESCREEN TIME: _____*Hours* _____*Minutes*

Qualified Mental Health Professional Signature Date

STATEMENT FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL AUTHORIZING ADMISSION TO A KANSAS STATE PSYCHIATRIC HOSPITAL

Name of patient | DOB | Age 0 | Sex

Patient's address | City | State | Zip | County

Based upon my screening of the above-named person, done by me in person and/or by review of this person's records and of reports concerning this person, and being familiar with the resources and services which are available within this community, I find that the needs of this person for the services indicated below cannot be adequately met in this community, and I therefore authorize that the following service(s) be provided at a state psychiatric hospital.

Check VOLUNTARY or INVOLUNTARY services authorized:

A. ☐ **VOLUNTARY care and treatment** (which this person has indicated to me that he/she wishes to be admitted for and which I believe he/she has the capacity to consent to (See KSA 59-2949(a)).

B. **INVOLUNTARY care and treatment** as specified below:

☐ EMERGENCY or TEMPORARY DETENTION AND TREATMENT pursuant to KSA 59-2954, or under the Court's EX PARTE EMERGENCY CUSTODY ORDER (see KSA 59-2958), or under the Court's TEMPORARY CUSTODY ORDER (see KSA 59-2959) if either are issued.

☐ MENTAL EVALUATION, including the examination(s) necessary to prepare the report to be submitted to the Court to assist in the trial of the issue of whether or not this person is a mentally ill person subject to involuntary commitment (see KSA 59-2961).

☐ INPATIENT CARE AND TREATMENT as may be ordered by the Court in any ORDER of CONTINUANCE AND REFERRAL (see KSA 59-2964) or ORDER FOR TREATMENT (see KSA 59- 2966), or ORDER FOR CONTINUED TREATMENT (see KSA 59-2969(f)).

Qualified Mental Health Professional Signature | Date

CMHC Address | Phone #

☐ Original to be filed with the Court (if involuntary proceedings)

☐ Copy to (State Hospital/SIA)

☐ Copy to CMHC (if courtesy screen)

EMERGENCY ROOM/HOSPITAL TRANSFERS: If the patient has been taken to any emergency room of any community hospital, or is currently admitted to any inpatient department at any community hospital, medical consultations must have been completed prior to any transfer of the patient to any state psychiatric hospital and the treating physician at the community hospital and the physician on duty at the state hospital must concur that the patient is medically stable and that the state hospital is capable of managing the patient's physical condition (See 42U.S.C. Sec. 1395dd). List below (1) the name of the local treating/emergency room physician and (2) the name of the physician on duty at the state hospital who has agreed to accept the transfer:

(1) Name | (2) Name

CERTIFICATE OF A PHYSICIAN, LICENSED PSYCHOLOGIST, OR A DESIGNATED QUALIFIED MENTAL HEALTH PROFESSIONAL

(to be attached to a Petition to Determine a Person to be a Mentally Ill Person Subject to Involuntary Commitment)

Name of patient | DOB | Age 0 | Sex

Patient's address | City | State | Zip | County

I certify that:

☐ I am a:
☐ licensed physician; ☐ licensed psychologist; ☐ qualified mental health professional designated by the head of a mental health center to make this certificate;

☐ I have on (*date*) personally examined the above-named patient and reviewed any available records, and on the basis thereof:

☐ It is my professional opinion that the patient is likely to be a mentally ill person subject to involuntary commitment for care and treatment as that term is defined in KSA 59-2946 (f), including that this patient:

- ☐ is suffering from a mental disorder to the extent the person is in need of treatment;
- ☐ lacks the capacity to make an informed decision concerning treatment, despite conscientious efforts at explanation or efforts to elicit a response from the patient showing an ability to engage in a rational decision-making process;
- ☐ is likely to cause harm to self or others or substantial damage to property of another;
- ☐ is not solely diagnosed with one of the following mental disorders: alcohol or chemical substance abuse; anti-social personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

  NOTE: all four of the above-described conditions must be applicable to this person in order for the patient to meet the legal definition of a mentally ill person subject to involuntary commitment.

☐ (OPTIONAL) For this reason, I recommend that the patient be detained and admitted to an appropriate inpatient treatment facility for further observation and treatment pending Court proceedings.

Signature of physician, psychologist or QMHP | Date

Name of associated facility/mental health center/clinic | Phone #

Business Address | City, State, Zip

- ☐ mental health center screening form attached
- ☐ other medical record or statement attached
- ☐ copy to:
- ☐ copy to:

State Hospital
APPLICATION FOR EMERGENCY ADMISSION (FOR OBSERVATION AND TREATMENT)
Pursuant to KSA 59-2954 (b) or (c)

0

Name of patient DOB Sex S.S.N.

Patient's address City State Zip County

Name of spouse or nearest relative telephone#

Address, if different from patient's

I request admission of the above-named person for emergency observation and treatment upon the following circumstances:

1. ☐ I am a law enforcement officer having custody of this person pursuant to the provisions of KSA 59-2953, &:
   - ☐ I will file a petition seeking the involuntary commitment of this person with the District Court of County, not later than the close of business on (date), or;
   - ☐ I have been informed by (*name*) that s/he will file such a petition. This individual may be contacted at: (*phone #).*
2. ☐ I am not a law enforcement officer, but I am familiar with the circumstances of this patient immediately preceding this application, and I will file a petition seeking the involuntary commitment of the patient with the District Court of County, not later than the close of business on (*date*).
3. ☐ I believe this patient to be a mentally ill person subject to involuntary commitment for care and treatment as defined in KSA 59-2946(f) and is likely to cause harm to self or others if not immediately detained. In support thereof I state that:

4. ☐ The following criminal charges are known by me to be pending against this patient:

   ☐ None ☐ It is unknown by me whether any charges are pending against this person.
5. ☐ Because this application is for admission to a state psychiatric hospital, the required statement from a qualified mental health professional is attached, having been obtained at the Community Mental Health Center.
6. ☐ Other documentation, medical records or reports concerning this patient are attached.
7. ☐ Other documentation, medical records or reports concerning this patient may be found and consulted at:

Signature Date

Printed name Time L.E.O. Badge #

Address City, State, Zip Phone#